Prescription Advantage Application Form

for Massachusetts residents 65 years of age and older or under age 65 and disabled

A. Applicant and Spouse Information

► **Is this form being completed by someone other than the applicant?** o Yes o No

If yes, provide the person's name and relationship to the applicant (ex. relative, friend, advocate)

Name: **Relationship:**

If you and your spouse live together, you must complete the *Spouse* sections even if he/she is not applying.

► **Who is applying on this application?** o You o You and your spouse

Naming your spouse as designee would allow us to speak to him/her if you are not available.

► **Would you like your spouse to be a designee on your account?** o Yes o No

► **If you both are applying, do you want to be designees for each other?** o Yes o No

Applicant (please print)

Last Name	First Name	MI	Jr/Sr/etc

Social Security Number (optional)	Are you enrolled in Medicare? o Yes o No *Medicare ID Number:	Railroad Retirement Number

Date of Birth	Gender o Male o Female	Preferred Language

Do you have a spouse who lives with you? o Yes o No If yes, complete the *Spouse* section below.

Spouse (please print)

Last Name	First Name	MI	Jr/Sr/etc

Social Security Number (optional)	Are you enrolled in Medicare? o Yes o No *Medicare ID Number:	Railroad Retirement Number

Date of Birth	Gender o Male o Female	Preferred Language

Are you a Prescription Advantage member? o Yes o No

If yes, provide your Prescription Advantage ID number:

B. Residence and Contact Information (please print)

Primary Street Address (No PO Boxes)	Apt.	City	State	Zip

Mailing Address (if different from above)	Apt.	City	State	Zip

Telephone Number (_____) _____

*If you have Medicare Part A or B, send a copy of the front of your Medicare ID card.

C. Household Information

► **How many relatives (besides your spouse) live with you and depend on you or your spouse to provide at least one-half of their financial support?**
Relatives may include anyone related to you by blood, marriage, or adoption.

Number of Relatives _____

D. Other Prescription Drug Coverage

Reminder: Send a copy of the front and back of your insurance card. If you have a creditable coverage plan, send a copy of a letter from the plan that verifies your creditable coverage.

1. Are you enrolled in a Medicare or creditable coverage drug plan? Provide the name of your plan.
Applicant: o Yes o No o Not Sure **Spouse:** o Yes o No o Not Sure
Plan name: *Plan name:*

2. Do you have any other health insurance? Provide the name of your plan.
Applicant: o Yes o No o Not Sure **Spouse:** o Yes o No o Not Sure
Plan name: *Plan name:*

3. If you have other health insurance, does it include prescription drug coverage?
Applicant: o Yes o No o Not Sure **Spouse:** o Yes o No o Not Sure

4. Do you receive health coverage through Medicaid (MassHealth or CommonHealth)?
Applicant: o Yes o No o Not Sure **Spouse:** o Yes o No o Not Sure

5. Do you receive coverage through a Medicare Savings Program? o Yes o No o Not Sure

E. Extra Help From Medicare

► **Are your savings, investments, and real estate (other than your home) worth more than the resource limits for Extra Help? Your answer will not affect your eligibility for Prescription Advantage.** Include assets you own by yourself, with your spouse, or with someone else. *Do not include* your home, life insurance policies, burial plots, or personal possessions. Refer to Side 1 of the *Prescription Advantage Rate Schedule Guide* for the current single and married resource limits. The limits can be found under the ***Medicare provides 'Extra Help'*** paragraph.

o Yes o No o Not Sure

Reminder: If you applied for Extra Help, send a copy of the determination letter from Social Security. If you do not have a determination letter, send a copy of your Extra Help application receipt from Social Security.

Reminder: If you applied for MassHealth Buy-in program, also known as Medicare Savings Program, send a copy of the determination letter you receive from MassHealth.

F. Employment and Disability Information

All applicants must answer question 1.
If you are under 65 years of age, answer question 2 regarding your disability status.

1. Are you currently working? If yes, how many hours per month do you work?

Applicant: o Yes o No Hours per month _____
Spouse: o Yes o No Hours per month _____

Reminder: Provide documentation if you answer YES to question 2 and you are under age 65.

2. Do you have a qualified disability? **Applicant:** o Yes o No
Spouse: o Yes o No

Send a **copy of one** of the following documents. Check the box next to the document you send.

APPLICANT

- o Your Medicare card;
- o Current Social Security Administration award letter for SSDI or SSI benefits;
- o Certificate of blindness from the Massachusetts Commission for the Blind;
- o Determination of disability from MassHealth or CommonHealth (Medicaid);
- o Written verification of SSDI or SSI benefits signed by an authorized Social Security Claims Representative on Social Security letterhead

SPOUSE

- o Your Medicare card;
- o Current Social Security Administration award letter for SSDI or SSI benefits;
- o Certificate of blindness from the Massachusetts Commission for the Blind;
- o Determination of disability from MassHealth or CommonHealth (Medicaid);
- o Written verification of SSDI or SSI benefits signed by an authorized Social Security Claims Representative on Social Security letterhead

G. Income Information

Reminder: ALL applicants must provide documentation to verify income. Refer to **pages 3, 4, and 5** of the *Application Instructions* for information regarding income calculation and the types of income documents you may submit.

ALL applicants must answer the following questions regarding Social Security income and federal income taxes.

► **Is Social Security your only source of income?** **Applicant:** o Yes o No **Spouse:** o Yes o No
► **Do you or your spouse file federal income taxes?** **Applicant:** o Yes o No **Spouse:** o Yes o No

Signatures

Please read the following statements and sign and date the bottom of this page. Because we require information regarding your household income, your spouse must also sign if he/she lives with you, even if he/she is not applying at this time.

I agree to abide by all Prescription Advantage regulations and will notify Prescription Advantage, in writing, within fifteen (15) business days of any change to my personal information which may affect my eligibility or level of benefits. This information includes, but is not limited to, changes in residence, marital status, income, and Medicare status.

I understand and consent to the fact that:

1. Prescription Advantage may share my personal information with other state and federal agencies, as well as with any other organization providing me prescription drug coverage, for the purpose of coordinating my Prescription Advantage benefits with my other prescription drug coverage; and,

2. Prescription Advantage may use my name, date of birth, address, social security number, and other identifying information to verify the information I have provided on this application, such as any information that I have provided about my income, with other state and federal agencies, including but not limited to the Massachusetts Department of Revenue and the United States Social Security Administration. Prescription Advantage may use the identifying information in conducting matches to confirm my eligibility for assistance and to detect fraud. Prescription Advantage may also match the identifying information that I provided on this application relating to my family members, such as my spouse, or my dependents.

I hereby certify, under the pains and penalties of perjury, that I have examined all the information on this form and the accompanying documentation and that it is true, complete, and correct to the best of my knowledge and belief. I further certify that any information I submit in the future related to this form and the accompanying documentation will also be true, complete, and correct to the best of my knowledge and belief.

If you are acting on behalf of someone who is unable to complete this form because of a physical or mental condition, by signing this form, you are declaring that the information submitted, and any accompanying or supplemental information is true, complete, and correct to the best of your knowledge and belief.

X_____**Date**_____
Signature of applicant (or designee if applicant is unable to complete this form)

X_____**Date**_____
Signature of applicant's spouse (or designee if spouse is unable to complete this form)

Sign and return to Prescription Advantage, P.O. Box 15153, Worcester, MA 01615-0153 or fax to 508-793-1133

For questions call Prescription Advantage Customer Service at 1-800-243-4636 or TTY for the deaf and hard of hearing at 711.

SELF-ATTESTATION NEW APPLICANT - INCOME FORM

Select why you are completing this form (check all that apply)

☐ You are applying for Prescription Advantage AND you have not filed federal tax returns in the last (2) calendar years

☐ You are applying for Prescription Advantage and requesting to remove income no longer received from your reported income

☐ Other, (specify) _____

Please print clearly and fill out all applicable income amounts.

SECTION A: Applicant Information

Last name (Applicant)	First name (Applicant)	Date of Birth
Last name (Applicant Spouse)	First name (Applicant Spouse)	Date of Birth

Street Address (where you are living in MA)	City	State	ZIP

SECTION B: Income Calculation

The income reported below is for calendar year: _____

- If you have NOT filed federal income tax returns in the last (2) calendar years list all gross annual income received in the previous year. The ***gross amount is before deductions, such as Part B or Part D premiums, and taxes and must include applicant & spouse.***
- If you are requesting to have income removed from your previous year's earnings enter the gross amount in the appropriate type, i.e., employment wages. If your reported income impacts your eligibility in the Prescription Advantage program and / or your membership category, you may be asked to provide supporting documentation.

Type (all applicable)	Gross Amount (Applicant & Spouse)	Income No Longer Received	Type (all applicable)	Gross Amount (Applicant & Spouse)	Income No Longer Received
Social Security	$	$	Business/Self-Employment	$	$
Employment Wages	$	$	Alimony	$	$
1099 - Income Reported	$	$	Rental Income	$	$
Unemployment	$	$	Veterans Taxable Benefits	$	$
Disability Payments	$	$	Taxable Refunds	$	$
Retirement	$	$	3rd Party Sick Pay	$	$
Railroad Retirement	$	$	Trust Fund	$	$
Pension / Annuity	$	$	Other **(specify)**, _____	$	$
IRA	$	$	Other **(specify)**, _____	$	$
Gambling	$	$	Other **(specify)**, _____	$	$
Capital Gains	$	$	Other **(specify)**, _____	$	$
Dividends /Interest	$	$	Other **(specify)**, _____	$	$
Total annual gross income = $_____			**Total income to be removed = $_____**		

Total gross income (total annual – income removed) = $_____

SECTION C: Signature (Required)

I hereby certify, under the pains and penalties of perjury, that I have examined all the information on this form and the accompanying documentation and that it is true, complete, and correct to the best of my knowledge and belief. I further certify that any information I submit in the future related to this form and the accompanying documentation submitted will also be true, complete, and correct to the best of my knowledge and belief.

If you are acting on behalf of someone who is unable to complete this form because of a physical or mental condition, by signing this form, you are declaring that the information submitted, and any accompanying or supplemental information is true, complete, and correct to the best of your knowledge and belief. ****Note* - If you are a Healthcare Proxy/Power of Attorney, you must complete an Authorized Representative Form specifically for Prescription Advantage.***

Sign name (Applicant)..... Date .....

Sign name (Applicant Spouse, if applying) ..... Date .....

☐ Check here if you are an Authorized Representative